HEALTH BENEFIT PLAN INDEPENDENT REVIEW PROCESS

UTAH INSURANCE DEPARTMENT
SUITE 3110 STATE OFFICE BUILDING
SALT LAKE CITY UT 84114
(801) 538-3077

INSURED'S CHECKLIST

The following checklist is provided so that you can be certain that your request for an independent review is complete: *(Please note, if one of these items are missing, it will delay the process of this request)*

_____(1) A completed, signed, and dated request form. The request form follows this checklist.

_____(2) A photocopy of the insured's insurance identification card or other evidence of coverage;

_____(3) A copy of the letter from the carrier that states: {*either (a) or (b}*

(a) the decision is final and that the claimant has exhausted all internal review procedures; or

(b) the requirement to exhaust all of the carrier's internal review procedures has been waived.

**You may request an independent review without exhausting all internal review procedures under certain circumstances. Call the Utah Insurance Department at 801 538-3077 for further information.

_____(4) For an **expedited** independent review, the completed Certification of Treating Health Care Provider for Expedited Consideration of a Patient's Independent Review form. (Page 5)

_____(5) For independent review due to service or treatment that was determined to be **experimental** or **investigational**, the completed Physician Certification for Experimental or Investigational Denials form. (Page 6)

If you need help in completing the request or if you do not have one or more of the above items, call the Utah Insurance Department at 801 538-3077 for assistance.

For a standard independent review or one that involves experimental or investigational service or treatment, send all paperwork to the address above or email to healthappeals.uid@utah.gov or fax to 801 538-3829.

For an expedited independent review, call the Utah Insurance Department at 801 538-3077 to determine the quickest way to submit the application and supporting information.

INDEPENDENT REVIEW REQUEST FORM

UTAH INSURANCE DEPARTMENT
SUITE 3110 STATE OFFICE BUILDING
SALT LAKE CITY UT 84114
801 538-3077

To request an independent review, this form **must be submitted to** the Utah Insurance Commissioner within **180 days** after receipt from your carrier of a denial of payment on a claim or request for coverage of a health care service or treatment, or rescission of coverage. The carrier's internal review process must be exhausted prior to requesting an independent review unless you are requesting an expedited review.

REQUESTOR'S NAME: _____
Insured _____ Claimant _____ Provider _____ Authorized Representative _____

INSURED'S INFORMATION: Insured's Name: _____
Address: _____
Home phone: _____ Cell: _____ Work: _____ **Email:** _____

INSURANCE INFORMATION: Carrier's Name: _____
Insurance ID Number: _____ Type of coverage: Individual ____ Group ____

EMPLOYER INFORMATION:
Employer's Name: _____ Employer's Phone: _____
Is the health coverage you have through your employer a **self-funded** plan? _____. Most self-funded plans are not eligible for independent review. Check with your employer.

HEALTH CARE PROVIDER INFORMATION:
Treating Physician/Health Care Provider: _____
Address: _____ Contact Person: _____
Phone: _____ Medical Record #: _____ E-mail: _____

REASON FOR CARRIER DENIAL: (Check one)
_____ The health care service or treatment does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.
_____ The health care service or treatment is experimental or investigational.
_____ The coverage was rescinded.

EXPEDITED REVIEW:
An expedited review is available if a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.
Is this a request for an expedited review? Yes _____ No _____
If yes, your treating health care provider **must** complete the Certification Of Treating Health Care Provider for Expedited Consideration of a Patient's Independent Review form.

EXPERIMENTAL OR INVESTIGATIONAL REVIEW:
If the denial of coverage is based on a determination that the service or treatment recommended or requested is experimental or investigational, your treating physician **must** complete the PHYSICIAN CERTIFICATION FOR EXPERIMENTAL or INVESTIGATIONAL DENIALS form.

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE:

In your own words, describe the disagreement with your carrier. Indicate clearly the service being denied and the specific date. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your carrier concerning the denial, any pertinent literature or clinical studies, and any additional information from your physician/health care provider that you want the independent review organization reviewer to consider.

SIGNATURE AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
To appeal your carrier's denial, you must sign and date this independent review request form and consent to the release of medical records.

I, _____, hereby request an independent review.

- I attest that the information provided in this request form is true and accurate to the best of my knowledge.
- I authorize my carrier and my health care providers to release all relevant medical or treatment records, including any records pertaining to HIV/AIDS, mental health, and substance abuse, to the independent review organization and the Utah Insurance Department.
- I understand that the independent review organization and the Utah Insurance Department will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else.
- I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has already been taken based on this authorization.

This release is valid for one year.

_____ _____
Written signature of Insured or legal representative Date

*****AN ELECTRONIC SIGNATURE IS NOT ACCEPTABLE*****

If legal representative: Parent_____ Guardian_____ Conservator _____ Other _____
Address of Authorized Representative: _____
Home phone: _____ Cell: _____ E-mail: _____

APPOINTMENT OF AUTHORIZED REPRESENTATIVE:
(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____
Written signature of Insured or legal representative Date

*****AN ELECTRONIC SIGNATURE IS NOT ACCEPTABLE*****

If legal representative: Parent____ Guardian ___ Conservator ___ Other _____
Address of Authorized Representative: _____
Home phone: _____ Cell: _____ E-mail: _____

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED INDEPENDENT REVIEW

(To Be Completed by Treating Physician)

NOTE TO THE TREATING HEALTH CARE PROVIDER:
Patients can request an independent review when a carrier has denied a health care service or course of treatment on the basis of a determination that the requested health care service or course of treatment does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Utah Insurance Department oversees requests for an independent review. The standard independent review process can take up to 45 days from the date the patient's request for independent review is received by our department. Expedited independent review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard independent review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function. An expedited independent review must be completed within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

Name of Treating Health Care Provider: _____
Mailing Address:_____
Phone Number: _____ Fax Number: _____E-mail: _____
Licensure and Area of Clinical Specialty: _____
Name of Insured: _____ Insured's Member ID:_____

CERTIFICATION:
I hereby certify that: I am a treating health care provider for _____and that adherence to the time frame for conducting a standard independent review of the insured's appeal would, in my professional judgment, seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; and that, for this reason, the insured's appeal of the denial by the insured's carrier of the requested health care service or treatment should be processed on an expedited basis.

_____ _____
Written signature Date

*****AN ELECTRONIC SIGNATURE IS NOT ACCEPTABLE*****

PHYSICIAN CERTIFICATION FOR EXPERIMENTAL or INVESTIGATIONAL DENIALS

(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the carrier's decision that the proposed therapy is experimental and/or investigational. I understand that in order for the insured to obtain the right to an independent review of this denial, as treating physician I must certify that the insured's medical condition meets certain requirements:

Name of Treating Physician: _____
Mailing Address: _____
Phone Number: _____ Fax Number: _____ E-mail: _____

In my medical opinion as the insured's treating physician, I hereby certify to the following: (Check **all** that apply)

(1) The insured has a condition that qualifies under one or more of the following:

_____ (a) standard health care services or treatments have not been effective in improving the insured's condition;

_____ (b) standard health care services or treatments are not medically appropriate for the insured; or

_____ (c) there is no available standard health care service or treatment covered by the insurer that is more beneficial than the requested or recommended health care service or treatment.

_____ (2) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the insured than any available standard health care services or treatments.

_____ (3) The health care service or treatment recommended would be significantly less effective if not promptly initiated.
Explain: _____

_____ (4) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the insured and which has been denied is likely to be more beneficial to the insured than any available standard health care services or treatments.
Explain: _____

Provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

_____

_____

_____

_____

_____ _____
Written signature Date

*****AN ELECTRONIC SIGNATURE IS NOT ACCEPTABLE*****